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## CLINICS.

### CLINICAL LECTURES.

*A Clinical Lecture on the best manner of employing Instruments in Cases of Stricture where much difficulty exists.* By SIR HENRY THOMPSON, Emer. Prof. Surg. in Univ. Coll. Hospital.

I have now to consider the question, How are you to deal with a case of stricture of the urethra in which real difficulty exists in passing an instrument into the bladder? Let a case be supposed in which attempts have been made, perhaps by several hands, and hitherto without success.

First, let me point out in what the chief mechanical difficulties in such a case might consist. There are four:—

1. Extreme narrowness of the stricture.
2. The stricture may be tortuous.
3. It may be complicated with false passages.
4. The urethra behind the stricture may be irregularly dilated and reticulated.

Difficulties of another kind, not mechanical, are frequently met with; these are two in number, and are to be considered hereafter—viz. (1) the stricture may be very resilient, and liable to become narrower, and to produce absolute retention on any instrumental contact; and (2) any use of the instrument may produce in the patient an attack of rigors.

1. Let us consider first the mechanical causes of difficulty, of which the first is extreme narrowness.

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In regard to this, the first thing you must do is to see the patient make water. The failures to pass the instrument may not necessarily have arisen from narrowing of the urethra or from tortuosity; there may be a false passage in the canal. It may, indeed, be that there is no stricture at all. No greater mistakes are made than those which occur with patients who have little or no stricture, either from the surgeon not knowing well how to pass the instrument, or from there being a false passage into which it enters, so that it does not reach the bladder at all. You are first, then, to see the stream of water, perhaps on more than one occasion, so as to estimate it fairly, and you will judge by that what size of instrument is to be used. And always let the instrument correspond with the size of the stream which you see; but it should correspond only in this way—the instrument should be a little smaller. You will sometimes see a patient who scarcely passes a stream at all; the urine issues only in a succession of drops. This being his constant, and not a temporary or accidental, condition, how very small must be the instrument which is adapted in size to traverse fairly the stricture.

The first step to be taken with such a case, after having ascertained, as I assume to have been done, the situation of the stricture, is to introduce very gently the smallest English gum catheter without a stylet, and try to insinuate it through the obstruction. For this purpose I have endeavoured to obtain some exceedingly small instruments, much smaller than any hitherto made.[1] This tiny catheter, which I show you, containing a slender steel thread rather than a stylet, may be used either with or without it. The value of this little instrument, after its extreme tenuity, is its ability to transmit a drop of urine through its interior, and so assure you of its position when the bladder has been reached, an assurance, I need hardly tell you, of great importance. It is worth while making a careful and somewhat prolonged trial, and if you succeed, the instrument is to be tied in at once and the route secured. If I fail with this, I then try a silver catheter of the smallest size.

But there is one very important matter in relation to the silver instrument—namely, that it is an extremely dangerous one in inexperienced or in incautious hands. Nothing is easier than to implicate its slender point in a lacuna, and if the slightest force be used, the point leaves the route and finds a track among the loose tissues outside the urethral mucous membrane, and thus a false passage is commenced. If you cannot train your hand to employ it with extreme lightness and delicacy, by no means use it. It should be held and moved with so much tenderness, that if the point meets with any resistance in its course, the fingers rather should slip down the shaft than communicate pressure to the instrument. Any kind of force in its use is not to be thought of—its only value is in its capacity for being insinuated between closely applied surfaces, and any sense of opposition to its point is a clear intimation that its route may lie right or left, but not straight on. It is not fit for the hand of a tyro, but when he is habituated to the use of somewhat larger instruments, the ability to use this will follow. A careful trial, however, with the very small gum catheter, first without and then with the stylet, will in many cases make this unnecessary; but these failing, I know no instrument so valuable as a very fine silver one with a little increase of size in the shaft, to render it steady. The final three inches should not exceed half the size of No. 1 of the English scale; the shaft should gradually rise to fully No. 2.

2. A stricture may be more or less tortuous; in other words, it does not necessarily follow the exact direction of the urethra.

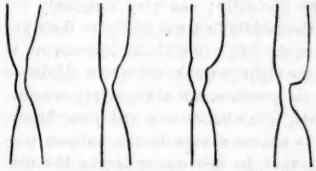
It may be a little on this side of the axis or on that, not necessarily in the middle. You may see this sometimes in the dead body; and you may infer it from experience on the living. When you have to deal with a very narrow or with a tortuous stricture, there are two quite dis-

[1] Messrs. Weiss and Son have taken great pains to accomplish this for me, and have produced some slender delicate instruments much smaller than No. 1, which have been of great service.

tinct systems of using an instrument, either of which you may employ. What I have to say, then, applies to the manipulation necessary in all cases of difficulty under the present and preceding heads; and I have reserved it therefore until now. First, the little instrument employed, whatever its nature, may be applied by what may be called "groping"—that is, by carrying the point in any and every direction, with the utmost care of course, until by chance it has entered into the stricture, as you may feel by the sensation of the point being "held" or "grasped." For this purpose very slender solid instruments are made of gum-elastic, of catgut covered or not with gum, or of whalebone, since these can be produced of rather smaller size than the hollow instruments which I have just described. In order to add to the chance, as is supposed, of finding the orifice, there are some of the first-named material, the ends of which are formed somewhat into the shape of a corkscrew, or are otherwise made to deviate from a straight line. All these are of French design and workmanship, but none have the advantage of being hollow, to demonstrate their presence in the bladder when they arrive there.

Now, I advise you not to rely on mere groping to find the orifice; it is exceedingly dull, mechanical work to be constantly groping for a considerable time on the chance of success.

There is a method of search, however, conducted on a fixed principle, which I much prefer and always employ. I advise you to adopt that, or any other you can devise, provided that it be a systematic one, and also an exhaustive manner of making the necessary exploration and researches for the orifice of the stricture. Some of you have often seen me apply it to patients in the wards upstairs. According to this manner you proceed systematically and examine each side of the urethra *seriatim*. We will suppose the urethra to require examination on four sides—a roof, a floor, a right side, and a left side. You are to take your slender silver catheter and slide its point delicately along each side successively from the orifice to the place of obstruction. If the orifice of the stricture is not *exactly* in the middle line, and we may fairly believe that it rarely is so, then there is one side of the passage which will more easily lead into the narrow way than any other. These diagrams will show what I mean. If I go down on this side I shall probably not get into the stricture; but if I slide



down gradually on the other I shall probably get the instrument in, because you see there is less obstruction on that side. Begin, then, by the roof. The roof is the firmest part, the least likely to furnish obstruction in the way of ducts or lacunæ, and by following it you will be most likely to carry the point in. The floor, on the contrary, is the softest, loosest, and most spongy part, and will be most likely to yield to the instrument and give way. If your first effort does not succeed, take the right side; if that does not do, take the left; if that fails, try the floor. If you are very careful, you may make the attempt in this manner for thirty or forty minutes without doing any damage; but if the patient suffers, or if he bleeds, or if you are losing patience, give up the task, or you may make a false passage, and increase the difficulty considerably.

3. The existence of a false passage leading out of the urethra, is another serious obstacle to the introduction of instruments into the bladder.

The principle which must guide your action here is to be very careful to avoid the side on which the false passage is. A false passage commences usually on the floor, and no doubt for a reason already mentioned—viz., the fact of the structures below being looser and more delicate than those above. When you examine a patient with a false passage, you may find

the instrument passing to its very end, notwithstanding which no urine flows. Hence the false notion of stricture at the neck of the bladder. When the instrument has thus passed, put your finger into the rectum, and you will know instantly whether there is a false passage; for, if so, there are only the coats of the bowel, which are very thin, between your finger and the instrument, so that you feel it very distinctly; and very commonly not in the middle line, but rather to the right or to the left. But if the instrument is in the right passage, the whole thickness of the prostate, not always very considerable, is felt between it and your finger. It is almost always in the bulbous portion that the instrument leaves the urethra and gets under the prostate. What you are to do, then, is to withdraw the catheter two inches or so, pass it on again, keeping as close along the upper part of the urethra as you can, ascertaining by means of the finger in the bowel that the instrument is not passing into the old route. But when a false passage exists, it sometimes constitutes the chief obstacle to the introduction of an instrument, for, as I have before hinted, the stricture itself may be only inconsiderable. The size of the stream will help to determine this point; and if, so far from being a mere thread, it has a volume equal to a No. 6 or 7 catheter, use a No. 5 silver one, so that you can guide it, and try each side of the urethra successively until you discover which it is that enables you to clear the orifice of the false passage. Remember the result, and you have a key to the difficulty which will enable you to overcome it with ease on the next occasion.

4. Difficulty presented by dilatation and reticulation of the urethra behind the stricture.

Suppose next, that, following these hints, you have carried the instrument through the stricture; there is a sort of grasp felt on attempting to move the instrument which is quite unmistakable. But that very "grasp," which you are so satisfied to feel, makes it less easy to manipulate the point of the catheter after it is through the stricture, and you may have a source of danger to encounter in the urethra beyond. Thus the mucous membrane, being sometimes reticulated from the presence of dilated lacunæ, it is easy to engage the point of the instrument in one of these, and make a false passage. Besides this, as the result of long continued fluid pressure and straining, the urethra behind the stricture is occasionally much dilated, and the whole surface is so irregular that it requires care and an acquaintance with this condition to traverse it safely. Here especially, with a small instrument already firmly grasped, you may require all the caution you can command in completing its safe course into the bladder.—*Lancet*, Jan. 1876.

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### HOSPITAL NOTES AND GLEANINGS.

*Unreduced Dislocation of the Head of the Humerus of one Month's Standing; Question of Fracture.*—There are few inquiries the diagnosis of which is more obscure, or the treatment of which is more difficult, than that of dislocation of the head of the humerus, complicated with fracture of the bone near the surgical, or through the anatomical, neck. If the nature of the case be recognized, it is doubtless the best practice to completely anæsthetize the patient, and to reduce the head of the bone by manipulation, and then to treat the case as one of fracture. The surgeon should always satisfy himself that the head of the bone has been replaced, as it is certain that there is no time or opportunity so favourable for the reduction of a dislocation as that which immediately follows the infliction of the injury.

T. H. D———, aged fifty-four, was admitted on August 27, 1875. He stated that he fell off a wagon of hay a month ago, striking his left elbow against a wall as he fell, and that when he got up he found that he could not use his arm. A surgeon saw him five hours afterwards, who "pulled his arm, but did him no good," and told him he had broken three of his ribs. His arm was bandaged to his side, but had to be released in three days, as he could not bear the pain. A week or so after the accident he was seen by another medical man, who put his foot

in his armpit and dragged at his arm, but failed to "put him right."

On admission, a dislocation of the head of the left humerus into the axilla was recognized. There was no crepitus. The next day chloroform was given to complete muscular relaxation, and the arm was rotated and twisted to break down adhesions which might have formed. A fair amount of force was used, and creaking sounds gave evidence apparently of the adhesions giving way. The limb was then manipulated by extension, rotation, etc., with a view to reduction, but without success. The shoulder was evidently more rounded, but on examining the limb more carefully, and placing the fingers on the head of the bone, the latter was found not to move. It was now apparent that in addition to dislocation there was fracture of the neck. The patient was put to bed with the arm bandaged to the side, and with the elbow well elevated. The next day the shoulder was considerably swollen and painful, and the bandages were removed, and hot fomentations, with tincture of opium, applied, the limb resting on a pillow. So soon as the swelling and pain had subsided, passive motion of the joint was practised daily, and on Sept. 24th he was discharged at his own request with improved mobility at the shoulder.

*Remarks.*—The interesting question in this case seems to be this: Was there fracture as well as dislocation at the time of the accident, and was the union broken down by manipulation? or was the bone broken by the force used to reduce the dislocation? It could scarcely have been the latter, because the force employed did not seem sufficient. In favour of the former is the *evidence of fracture*, as, according to the man's statement, the surgeon who first saw him said he had broken his ribs. Assuming this to be the correct view we have here a demonstration of the possibility of breaking down union of fractured ends of bones, one month after the accident, without using any great amount of force.

In a recent number of the *Guy's Hospital Gazette* may be found the record of an almost identical case, in which Mr. Howse pursued a similar line of treatment with the same result. He does not mince matters, however, for he says that "in attempting to violently break down the adhesions he fractured the humerus." Dr. Sheen believes that it is scarcely possible to fracture a perfect humerus by such means unless both ends were fixed, and extreme violence used.—*Lancet*, Feb. 5, 1876.

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*Case of Paracentesis Pericardii; Recovery.*—The fact that the operation of tapping the pericardium for the removal of effused fluids is still *sub lite* renders the record of every case in which this operation has been performed peculiarly valuable and interesting, whatever the ultimate issue. In the subjoined case the benefit derived from the treatment was marked, and it is scarcely too much to say that the patient's life was actually saved by drawing off the serous fluid, which was found to measure forty-two ounces.

For the notes of the following interesting case we are indebted to Mr. Thomas Elliott, M.B., late house-surgeon in the Bristol General Hospital.

John M———, aged sixty, a carpenter, was admitted into Bristol General Hospital, on April 26th, 1875. Forty years ago he had rheumatic fever, and again two years later. His heart, he stated, was affected two years prior to the first attack. After these illnesses he enjoyed very good health till the close of the year 1874. He served as an "army carpenter" out in the Crimea, where, to use his own expression, he had "a lot of rough work." A month before Christmas, 1874, he was confined to bed for a week with rheumatism. For the two months prior to admission he had been "complaining," and troubled with a cough, and two weeks before admission his feet and legs began to swell.

On admission there was general anasarca, shortness of breath, and a feeble pulse. Heart-action rapid and irregular, with an indistinct systolic mitral bruit. Lungs anteriorly resonant, posteriorly resonant at right base, dull at left base; respiration exaggerated over right side, tubular at left base.

On April 28th the patient was much worse, apparently moribund. Breathing very oppressive, and could only be carried on when the man was lying on the left side, and slightly on his face. The face was of a livid colour; veins in neck full and tortuous, but not pulsating. Heart's apex could not be seen or felt; area of dulness greatly increased, but difficult to define on account of external œdema. The sounds were very distant and indistinct, almost inaudible. Lungs resonant anteriorly and at right base, dull at left base; respiration exaggerated over right side, tubular at left base; no appreciable difference between the two sides in conduction of voice sounds.

From these symptoms and signs Dr. Burder concluded that the patient's great and immediate distress was due to dropsy of the pericardium, and that therefore paracentesis should at once be done. The operation was performed by the house-surgeon (Mr. Thomas Elliott) by means of Dieulafoy's pneumatic aspirator, the needle being inserted between the fifth and sixth ribs, and an inch to the right of the nipple. Forty-two ounces of clear, pale, straw-coloured fluid were drawn off. Towards the close of the operation the apex of the heart was felt to strike once or twice against the needle, but it ceased on placing the needle more horizontally. It is here worth stating, especially from a practical point, that for cases of paracentesis the needles of the aspirator might with advantage be graduated. At times it is extremely difficult to estimate how far the needle has penetrated, as it was in this case, where there was a considerable amount of external œdema.

The patient expressed himself as easier after the operation, but it was not till some hours after that there was any marked improvement.

On April 29th the patient looked much better; the face was of a better hue, breathing much easier, and he could lie on either side or on his back. Respiration 50 per minute; pulse feeble. Dulness over base of left lung diminished, and not extending so high upwards. Respiration over same region much more audible, with some moist sounds. Area of heart's dulness definable, sounds not so audible as immediately after tapping. On April 30th the improvement was greater, the pulse was much stronger, and the general anasarca had gone down a good deal. On May 2d he said that he had slept but little the last two nights, on account of continued coughing, but the next night he slept much better. On May 3d he could lie on either side, but said that if he did so he must be well over on his face, but he preferred lying on the left side. Heart-sounds indistinct; lower extremities more œdematous.

From this time he continued to improve, and on May 31st the dropsy had entirely disappeared and the heart's apex could be seen and felt beating about an inch below the left nipple. The area of dulness was definable and greatly diminished; the sounds were louder, and an indistinct bruit, apparently louder towards the base, but not carried up along the large blood-vessels, could be heard. There was still a line of dulness posteriorly at right base, where also the respiration was feeble. After this he sat up daily, but if he made any exertion he suffered at once from dyspnœa and palpitation. The heart's beat was less distinct and was more to the outer side of left nipple than before; sounds irregular and confused.

On July 6th he was discharged as an out-patient, much improved, and able to move about more freely.—*Lancet*, Jan. 8, 1876.

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*A Case of Aortic Aneurism giving Rise to General Dropsy; Autopsy.*—The following case at the Seamen's Hospital under the care of Dr. RALFE is interesting, not merely from the difficulties attending the diagnosis, but also from its exhibiting a rare complication arising from the pressure of the aneurismal tumour. The notes of the case (condensed) have been furnished by Dr. H. Law, the house physician.

S. H. G——, aged thirty-seven, was admitted January 27th, 1875, complaining of general dropsy and chronic dysentery. He stated that his general health had been good till twelve months ago, when he had rheumatic fever, for which

he was treated at the Shanghai Hospital, his employment being that of a pilot on Chinese Rivers. After his discharge from the hospital he acquired dysentery, and three months before his admission dropsy set in, beginning in the lower parts and gradually invading the general integuments. No urinary derangement had been noticed.

When admitted he presented great general œdema of all parts below the neck, slight lividity of face, occasional cough with frothy sputum, dyspnœa on exertion. No thoracic abnormal dulness could be made out; heart's impulse barely perceptible through the greatly distended integument; sounds feeble; coarse crepitation at the bases of both lungs. No increase of hepatic or splenic dulness. Apparently some fluid in abdominal cavity. Urine diminished in quantity; no albumen. The stools were frequent (five to twelve a day), bloody, lumpy, and slimy. No history or evidence of syphilis.

The dysentery, under the castor oil treatment, yielded about the end of April. The dropsy increased till the legs and arms attained an enormous size, but in other respects for some time he improved. The shortness of breath was trifling and never paroxysmal, the cough abated, and he had no pain. Occasionally a faint short murmur of a rough character, intensified after a forced inspiration, was audible at the sternal end of the sixth left costal cartilage, not conducted in any direction. The urine remained free from albumen till a few weeks previous to his death. Puncture of the legs gave him relief for a short time, but effusion into the left chest presented itself about the end of June, and he sank. Death occurred on June 30th. Some time before his death a naval surgeon visiting the hospital recognized the patient, and remembered his having been in the Chinese Hospital; and he stated that it was thought at that time the man had some cardiac valvular mischief.

At the post-mortem examination a considerable quantity of fluid was found in the left pleura and abdomen. The pericardium was adherent, and a sacculated aneurism of the ascending aorta developed chiefly to the right side and posteriorly; from this aneurism another, smaller, projected forwards in close contact with the right auricle, which no doubt during life was pressed on by it; valves healthy and competent. The other organs presented nothing of special interest.

Dr. Ralfe observed that the difficulties attending the diagnosis of this case were of no ordinary kind. The history of the case, the statement that a valvular lesion had been detected some months previously, the presence of general dropsy, and a certain degree of bronchitis, led to the supposition that the obstruction to the circulation lay in some defect of the valves. Nor was the absence of any murmur that could be considered endocardial, opposed to such a view. At the same time, the possibility of the obstruction being caused by some thoracic tumour was not lost sight of. The patient being naturally fat rendered it difficult to detect any increase of abnormal dulness, and this difficulty was augmented by the dropsy in the integuments. Naturally, however, from the position and direction of the tumour, the dulness, even in a leaner person, would not have been very appreciable. The dropsical condition of the integuments also prevented an impulse being communicated. There was no pain, and all the usual pressure symptoms of thoracic tumour were absent. Dr. Ralfe thought the condition revealed by the post-mortem sufficient to account for the dropsy. The right auricle, when charged with blood during life, would be in contact with the smaller and laterally projecting aneurism, and thus a considerable amount of obstruction to the circulation would be produced. —*Lancet*, Jan. 15, 1876.

## MEDICAL NEWS.

### ORIGINAL ARTICLES.

*Epilepsy; One Case cured and two benefited by the Use of Bromide of Potassium, in gradually increasing doses, combined with Oxide of Zinc.* By E. G. Coleman, M.D., of Arkadelphia, Arkansas.

Case I. J. T., a male aged 35 years, has had epileptic attacks for four years. The primary cause of the disease was a

blow on the head, in being thrown from a horse. Epilepsy developing itself, he became subject to monthly attacks, with paroxysms occasionally intervening.

Having regulated his digestion, which was in a disordered state, I began the pot. bromid. with twenty grain doses ter die (given in a saturated solution), and increased the amount each day one and a half grs., till he had taken one hundred and sixty-five grs. per diem, or 55 grs. at a dose; the medicine being taken before each meal. This amount being continued for several months, and no relapses occurring, I decreased the dose as it had been advanced, until he ceased to take the medicine. During this period, I gave the zinci oxid. in two grain doses after each meal. Two years have now passed since the cessation of treatment, and he has had no further trouble, to within a few months ago, when I saw him.

Case II. D. B., aged 31 years, was attacked when quite young with a severe type of pneumonia, and from that time has been subject to epilepsy; the paroxysms, at first mild, became more and more frequent and severe, until they amounted to several during the day, and one or two at night. These attacks were not regular, sometimes ceasing for a day or two, to again recur as usual. Began with 20 gr. doses, and increased as in the previous case to one hundred and sixty-five ter die, when he became so thoroughly brominized that he refused to take the medicine; during this period he was clear of attacks, but, reducing the quantity to one hundred and twenty grs., they again returned, though greatly modified in frequency and severity. Gave zinci ox. two grs. after each meal. Patient left the State, and I have not heard from him since.

Case III. B. E., male, aged 20 years. When but a child a violent attack of "typhoid fever" seized him, and he was left in an epileptic condition, with paroxysms frequent (3 or 4 per diem), though mild. When first he came under observation and treatment, his mind was notably impaired (almost complete dementia), and the one subject which occupied his thoughts was his cure As, in the previous cases, he had taken the bromide, I began with sixty grs. per diem, though with but little hope as to permanent benefit. He improved, however, beyond my expectations, and continued to do so as long as he was under my charge, but distance prevented intercourse, and I have not heard from him in a long time.

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*Case of Strangulated Inguino-scrotal Hernia, with Omental Tumour; Herniotomy; Recovery.* By H. V. Passage, A.M., M.D., Peru, Indiana.

Sept. 4, 1875, I was called to Cass County to see a large, muscular man of good constitution, æt. 41, who had been labouring under the pain of a strangulated hernia for about thirty-six hours. I received the following history from the patient and his family physician: Twenty-seven years ago, when he was 14 years old, he had a fall from a tree, which produced (besides other transient injuries) an inguinal hernia of the left side, which was reduced without trouble. Since that time he has been continually troubled with hernia. On the morning of Sept. 3d he went out to the field to plow, and feeling the hernia descend he attempted to reduce it by taxis (as he had done on former occasions), but failed. While he was on his way to the house, he felt the hernia come down with a rush (as he expressed it). He immediately sent for the two Drs. Quick of Waverly, and they in turn sent for Drs. McGee and Laramor of Logansport. Attempts at reduction were kept up until four o'clock P. M. of the next day, when I performed herniotomy. When I cut down to the peritoneal covering, I found the stricture outside the sac. Passing the index finger of the left hand beneath the stricture, I cut it with Cooper's hernia knife, made mild attempts at reduction, and then opened the sac. Considerable fluid escaped, and the solid contents came to view. Upon examination they proved to be two tumours partially attached to each other, and both attached to the omentum only. They were of a fibro-cellular character, and weighed eleven ounces and one drachm. Having no other attachment than the omentum, they were easily detached and removed. The small amount of omentum

contained in the sac readily receded into the abdomen.

The wound was closed with silk ligatures, which were removed on the 6th day, and on the 15th day the patient was up. So far as I know tumours of the omentum are rare. The only cases I have seen reported are two by Dr. J. T. Miner in the *Buffalo Medical and Surgical Journal* for , 1875. When the sac of a hernia is habitually occupied by omentum, the latter tissue becomes indurated and thickened.

In conducting a dissecting room for private classes for the last fourteen years, I have frequently observed a hypertrophied condition of the omentum, but have never witnessed anything like the specimens in this case. At present (six weeks after the operation) the man is going about without a truss. The operation produced a radical cure.

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*Four drachms of Fluid Extract of Belladonna swallowed; Tincture of Opium given as an Antidote; Recovery.* By C. Y. Slagle, M.D., of Winnebago City, Minn.

I was called in haste January 16, 1876, at 7 P. M., to see A. T., aged 20, who was reported to have become suddenly insane and violent.

Found him in a state of wild delirium, heart and nervous system much excited, pupils widely dilated, with dryness of the fauces and throat, intense thirst, etc.

He would make sudden starts, and look wildly around as if labouring under some frightful hallucination, so that it required at times two or three stout men to hold him on the bed. After observing him narrowly for a few moments, I concluded that he was labouring under the influence of some powerful narcotic poison, probably self-administered, as his habits were known to be somewhat irregular. It was evidently a *deliriant* narcotic, and, therefore, probably either belladonna, hyoscyamus, or stramonium.

I attempted during an interval of calm to administer an emetic of ipecac, but he immediately spit it *out*.

I then at once applied chloroform to his nose, to the influence of which he appeared remarkably susceptible, requiring only a moment to anæsthetize him.

A vial was found on the floor of his room, indicating at what drug store it had been obtained, and which contained about half a drachm of a dark, thick liquid, which I soon ascertained to be Fd. Ext. Belladonna.

Having no stomach pump at hand, but remembering to have seen the account of the experiments of Dr. S. Weir Mitchell and others, "On the Antagonism of Atropia and Morphia" (*Am. Journ. Med. Sciences*, July, 1865), I at once concluded in this seemingly desperate case to give the tinct. of opium, which I did when he recovered from the anæsthesia, so that he could be induced to swallow liquids.

I administered about *four drachms* of tinct. opii within a space of thirty minutes, and found that I could dispense with the chloroform thenceforth, as he manifested decided symptoms of the influence of opium before I gave the last dose. He speedily quieted down into an opium slumber, and ere an hour from first dose of laudanum he was sleeping a deep narcotic sleep, which seemed for a moment to demand artificial respiration and stimulants, but neither were resorted to.

After about three hours of deep slumber, he began to manifest symptoms of returning consciousness (10 P. M.), called for water, of which he was given a mouthful every 20 or 30 minutes, circulation and breathing gradually grew better until about 2½ A. M., when he vomited about a pint of dark semifluid, mixed with partly digested food, after which his recovery was rapid, without any untoward symptoms, or any further treatment whatever.

On visiting him next morning he gave the following history of his case: During the forepart of the day of this occurrence, he had been suffering from headache, at 2 P. M. he ate, however, a pretty hearty meal, and in about three-fourths of an hour (the headache increasing) he consulted a "*doctor*," who prescribed as follows:—

"℞. Fd. Ext. Belladonna ℥j. Sig.—Take *ten* (10) drops every half hour until pain ceases."

He states, and his cousin corroborates his statement, that he took a dose then (2¾ P M.), and within the period elapsing until six P. M. that he took five doses,

and not even dropping it out of the vial, but taking at first about half teaspoonful, and increasing to at least a teaspoonful at a dose, pouring it out carelessly into a beer glass, as he had no idea or caution as to the poisonous nature of the drug. Indeed, from the very best testimony, we can be sure that he took at least *four drachms of Tilden's Fd. Ext. Bellad. in a space* of three and one-quarter hours (last dose at 6 P. M., one hour before I saw him).

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## DOMESTIC INTELLIGENCE.

*Salicylic Acid in Acute Rheumatism.*—In the current number of the *Monthly Abstract of Medical Science*, page 107, will be found an article giving the results of this mode of treatment in Prof. Traube's hands. In the *Boston Medical and Surgical Journal* for Feb. 24, Dr. CHARLES P. PUTNAM records a case which is quite as striking as Traube's.

Alice B., five years old, was thoroughly chilled while skating on February 5th, and for several days after had a hot skin, a coated tongue, and no appetite. On the 9th she lay on the bed most of the day. On the 10th she remained in bed. On the 11th, in the morning, her pulse was 120, her temperature (axillary) 102.7°. In the evening, pulse 131, temperature 103.5°. During the latter part of this day she complained much of pain in the muscles of the thigh, in the groin, and in the ankles. She would not move her lower extremities, and could be moved only with great pain. Skin dry. No swelling nor redness of any joints or of other parts of the body. On the 12th the general state was as before; pulse 120, temperature 103°. During the day the hands became painful and sensitive, and the knuckle-joint of the third right-hand finger was slightly swollen and rose-coloured.

On the 13th, pulse 130, temperature 102.7°. She had slept somewhat, with five grains of Dover's powder, but the pain and tenderness of the extremities had increased very much, so that the patient lay quite helpless, cried out when touched, and was moved only with the greatest difficulty. Most of the joints of the hands and feet, especially the joints between the first and second phalanges of the right hand and foot, were swollen and rose-coloured. Movement of the jaw also caused pain.

Salicylic acid was prescribed, five grains in wafers every hour when the patient was awake. The treatment was begun at two P. M., and eleven doses, making almost one drachm, had been given at ten A. M. next day. No tinnitus aurium was observed by the patient. After the first three doses there seemed to be some improvement, for though the physical appearances remained unchanged, the patient's spirits were better.

After the seventh dose she went to sleep, and was quiet most of the night, only waking often enough to take two more doses. In the morning she turned over in bed, moved the bedclothes with her hands, and wanted to be dressed.

On examination it was found that the redness had left all the joints; they could be moved without pain, and only a moderate œdematous swelling marked the affected parts. The patient complained only of slight itching of the hands and face.

At ten A. M., pulse 120, temperature 101.6°. At six P. M., pulse 124, temperature 102.4°. Five grains of salicylic acid were ordered every two hours during the night, but only three doses were given, as the patient seemed quite comfortable, and slept. On the 15th (forty-eight hours after treatment began) the temperature was 99.9°.

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*Bromide of Potassium in Saccharine Diabetes.*—In one of the earlier numbers of the *American Practitioner*, Prof. AUSTIN FLINT reported three cases of diabetes mellitus treated by the bromide of potassium, and suggested to physicians to make trial of this agent "in order to determine whether it be not entitled to be classed with other remedies which are sometimes useful." Its usefulness seemed to be clearly manifested in one of the cases detailed by Dr. Flint.

An esteemed medical friend, Dr. Jas. Ely, of Milton, Ky., writes that he is now

treating a case of saccharine diabetes with large doses of the bromide of potassium and tincture of digitalis. "I rely," he says, "on the potash salt to relieve pain and contract the capillary arterioles, and the digitalis to give tone to the heart and arteries, relieve the blood-stasis in the brain and spine, and thus prevent the dilatation of the arteries and the degeneration and decay that follow in the brain and spine. My patient is much better and has better use of his limbs, suffers no pain, has recovered his sexual appetite, while his skin has become moist and natural, but in spite of my injunctions he will sometimes disobey orders and eat farinaceous food, always to his injury."

It is to be hoped that the suggestion of Prof. Flint will be acted upon by other physicians, and the true therapeutic value of the bromide of potassium as a remedy in diabetes be determined. The suggestion of Dr. Ely to use the tincture of digitalis at the same time may be of some value also.—*American Practitioner*, Jan. 1876.

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*Reported Death from Ether.*—Dr. FINNEL presented to the New York Pathological Society (*New York Medical Journal*, Feb. 1876) the larynx of a patient who recently died at the Homœopathic Hospital while being operated on for the removal of a necrosed portion of the superior maxilla. The only abnormality noticed in the specimen was œdema of the larnyx. The history of the patient was, that he had suffered from necrosis of the maxilla, and it was determined to remove the sequestrum by operation. After having etherized the patient sufficiently, an incision was carried through the lip, and extended in a semicircular direction over the upper jaw. When the operation had proceeded thus far, the patient became cyanosed and died. It was suspected that blood had passed into the trachea, and to remedy this the patient was held up by his heels, but without effect. The time from commencing the administration of ether till death ensued was ten minutes. The amount of ether used was two and a quarter ounces. At the autopsy, no trace of blood could be discovered in the trachea. The heart was fatty, and weighed six ounces. No lesions could be discovered in any of the other viscera. A strong smell of ether was discoverable in the brain. The anæsthetic employed was the purified ether manufactured by Dr. Squibb.

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*Sphygmograph.*—The *New York Medical Journal* for January, 1876, contains a description, by Dr. A. T. KEYT, of an instrument, devised by him, adapted as a "sphygmograph, sphygmometer, cardiograph, cardiometer, and to other uses." It is founded on the same principle as the sphygmometer invented by Dr. Herrison, and a description of which was read before the Academy of Sciences of Paris some forty years since, and of the sphygmoscope of Dr. Scott Alison, an account of which is published in the Proceedings of the Royal Society for Jan. 1856, and of that of Dr. E. A. Pond, of Rutland, Vt., exhibited to the Suffolk District Medical Society, Nov. 27, 1875.

The mechanism by which the pulsations of the arteries and heart are exhibited by tracings is different from that of Marey's instrument, and seems to be ingenious.

Time and further experiments with the instrument will be required to demonstrate the superiority claimed for it over Marey's and Holden's instruments.

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*Pennsylvania State Board of Health.*—An act has been passed by the Senate of Pennsylvania, and is now before the House of Representatives, for the creation of a State Board of Health, to consist of five physicians, to be appointed by the governor. The duties required of them are *onerous*, and they are to receive *no salary*, but the actual personal expenses of any member while engaged in the duties of the Board shall be allowed and paid. Eight thousand dollars are appropriated for the purposes of this act and the expenditures properly incurred.

The provisions of this act do not seem to us to be very promising of useful results. Gratuitous labour is rarely well performed, and to require services of physicians that would not be demanded of any other class of citizens is altogether unjust and unworthy of a rich State. It is also to be feared, that, as the appoint-

ment of the members of the Board rests with the Governor, political influence rather than merit will govern the choice.

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OBITUARY RECORD.—Died, suddenly, in New York, on the 2d of January, in the 67th year of his age, JOHN R. VAN KLEEK, an esteemed physician of that city.

—— Suddenly, Jan. 20, 1875, at Oakland, Cal., Dr. E. LEE JONES, President of the Alameda County Medical Association, for many years an honored and influential practitioner of the city of New York.

—— At Sacramento, Cal., Feb. 18, THOMAS M. LOGAN, M.D., Secretary of the State Board of Health, and late President of the American Medical Association.

## FOREIGN INTELLIGENCE.

*A Remarkable Case of Aneurism.*—On the 25th Jan. last, Mr. OLIVER PEMBERTON, of Birmingham, tied the external iliac artery in a case presenting features of unusual occurrence and interest. The patient, a country gentleman of forty-seven, had led a life of great activity, especially in horse exercise; had been syphilitic, but was otherwise vigorous and healthy. Six months previously an aneurism formed in the left popliteal region; shortly after a second, at the apex of Scarpa's space; and when seen (Jan. 11th) by Mr. Pemberton, there was a third under Poupart's ligament, all being in the same limb. The lower tumours were as large as the closed hand, and the upper the size of a goose-egg. The artery was secured about an inch from the bifurcation by an antiseptic ligature—which Professor Lister specially prepared by a new method which he has just devised, and which, as soon as he has perfected its details, he intends to bring before the notice of the profession. The immediate result of the operation was that all pulsation ceased in three aneurisms, and has never returned (nine days having now elapsed). The patient is well, the pulse having never exceeded 84, and the wound without disturbance under antiseptic dressings.

It need hardly be said that the all-important question here was, to what extent would the collateral circulation be established? How much of the limb could be preserved from gangrene? Let the position of affairs for a moment be reviewed. The main artery, extending from the seat of ligature below the bifurcation of the common iliac to a little above the origin of the anterior and posterior tibials, arrested, *at four distinct points*, by absolute barriers to circulation —*by one ligature* and three solid aneurisms! Despite these difficulties the existing conditions seem to assure the preservation of the limb to about the middle third of the leg, a marvellous instance of what collateral circulation can do when tried to its uttermost.—*Lancet*, Feb. 5, 1876.

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*Anæsthetics in the London Hospitals.*—From a report on this subject published in the *British Medical Journal* (December 25, 1875), we learn that at St. Bartholomew's Hospital, ether, chloroform, and nitrous oxide gas are used; ether preceded by nitrous oxide gas is used in by far the greater number of cases. Chloroform is used for very young children, and in operations about the mouth and nose which are likely to last some time. Nitrous oxide gas is employed for short operations, such as extraction of a tooth or opening an abscess. Nitrous oxide gas and ether are administered by means of Mr. Clover's apparatus, which is admirably adapted for that purpose. Until January, 1875, chloroform was used, says Mr. Mills (chloroformist to the Hospital), for nearly all cases; but I found that, while chloroform frequently depresses the heart's action in long operations, ether stimulates it. It rarely happens that there is any persistent sickness after the inhalation of ether; I have met with but one instance in nearly nine hundred administrations, and in that case it lasted about twelve hours, at the expiration of which time the patient was able to take food well. Ether does not appear to be much less likely to cause vomiting at the time of the operation than chloroform, but it certainly causes much less after-sickness. Chloroform is used

in long operations about the mouth and nose, because: 1. The narcosis of chloroform lasts longer than that of ether; 2. In many operations, as for cleft palate or removal of the tongue, it is necessary to keep a gag in the mouth, which comes very much in the way of a face-piece, such as is necessary for the administration of ether; while chloroform can very conveniently be given on a piece of lint; 3. In operations for cleft palate, too, there is another objection to the use of ether, in the fact that it excites a flow of viscid saliva, and is apt to induce coughing. In delicate operations about the eye, I prefer chloroform, as it causes less congestion. In cases of fracture which require an anæsthetic whilst the parts are being placed in apposition during the time the muscles are relaxed, chloroform is preferable, because patients recover from its effects quietly, the inhalation of ether being generally followed by a state of noisy delirium and struggling, which would be likely to displace the fractured ends and necessitate their readjustment.

At Guy's, chloroform is the anæsthetic which is almost invariably used.

At the London Hospital ether has been chiefly employed since 1872. Since the introduction of ether the hospital has not contained any case in which death has resulted from its use nor during its administration.

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*Comparison of the relative safety of Ether and Chloroform.*—Dr. A. D. VALLETTE, in his "*Clinique Chirurgicale de l'Hotel-Dieu de Lyon*," devotes a lecture to this subject, in which he pronounces unhesitatingly in favour of the former. He does not deny that deaths occasionally occur under the influence of ether; but in the cases he has been able to collect, there is a remarkable difference between these and the similar accidents from chloroform. A large number of the fatal cases under chloroform have occurred when the anæsthetic was being administered to a patient apparently in good health, and suffering from some trivial local malady. On the other hand, those occurring under ether have always been in cases of the gravest character, and in which the patient was either exhausted by previous disease, or suffering from the shock of some severe injury. Again, he points out that death, when resulting from the effects of ether, has always been preceded by warning symptoms; whereas with chloroform it has often been sudden, and utterly without warning of any kind. He tells a somewhat amusing tale of Bonnet, relating to this subject. Bonnet, although he had lost several patients from chloroform, persisted in continuing its use on account of its greater convenience. At last, he himself wished to have some anæsthetic during the extraction of a tooth. When seated in the chair, ready for the operation, the dentist asked him, "What do you say, M. Bonnet; shall we use ether or chloroform?" He reflected a moment, and then replied, "Use ether." "From that day chloroform was banished from his wards in the hospital, and from his practice in the city."—*Brit. and For. Med.-Chirurg. Rev.*, Jan. 1876.

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*Ether and Chloroform in Vivisections.*—Prof. SCHIFF, of Florence, in his account of the plan pursued in his experiments on living animals, gives numerous reasons for preferring ether to chloroform, and states that etherization, carried to the last grade of insensibility, never becomes dangerous to life as long as the movements of respiration are maintained. Even when the inhalation of ether is carried further, and death appears to have supervened, life may be restored if, at the moment of the paralysis of the thoracic walls, a species of artificial respiration is immediately commenced. His experience has proved that in more than 3000 cases, in which ether was employed with the intention of preserving the life of the animals, and with the adoption of the necessary precautions, there was not a single case of death. Chloroform, on the other hand, destroyed a considerable number of animals when he wished to push the anæsthesia to the penultimate grade, that is to say, until the contraction of the diaphragm became so weak that an aperture in the abdominal cavity no longer caused a prolapse of the intestine. He had assured himself that in etherization the pressure of the vessels

is maintained at a height which is almost normal, and always compatible with the continuance of life, even after the cessation of the automatic respiration, and he has ascertained by the manometer that the sanguineous pressure is raised before the moment of death. On the contrary, in the case of chloroform, it has been found by the manometer that under similar circumstances the pressure of the blood is lowered before the automatic respiration has ceased, and the pulse has been often seen to disappear almost entirely in the manometer, the pressure of which fell to twenty-five or thirty millimetres while the animal was still breathing by its own efforts. Dr. Schiff thinks that chloroform ought to be banished from practice as an anæsthetic, except in cases where there is an extraordinary resistance to the effects of ether, and even then it might be allowable to mix a little chloroform with the ether, and to commence the anæsthesia, which may afterwards be continued with pure ether.—*Brit. and For. Med.-Chirurg. Rev.*, Jan. 1876.

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*Sudden Death during an Operation in which Chloroform was administered.*—On the 22d of January last, a death occurred in the operation theatre of Dr. Steevens's Hospital under somewhat peculiar circumstances. A young man, about 23 years of age, came to the hospital with a crop of venereal warts and chronic phimosis. Circumcision was decided upon, and, as the operation was a comparatively trifling one, he was advised to bear the pain without having recourse to anæsthetics. He, however, urgently requested to be put under the influence of chloroform. Accordingly, after the heart had been duly examined, and its sounds discovered to be normal, the operation commenced. The radial and temporal pulses were both full and strong, and all went on satisfactorily till suddenly, without a moment's warning, the countenance became livid and the circulation stopped. The operation was at once suspended, and artificial respiration was at once had recourse to, and kept up for more than an hour. Galvanism, cold affusion, strong solution of ammonia, and other restoratives, were all tried, but without avail. The man never recovered consciousness. The quantity of chloroform used was small, scarcely amounting to two drachms and a half, and none had been administered for upwards of a minute before the fatal symptoms appeared. An inquest was held on the body on Monday, the 24th, and evidence was given as to the cause of death. The jury returned a verdict to the effect that the man had died while under the effect of chloroform administered to him at his own request. They, at the same time, entirely exonerated the hospital staff from any blame in the matter, as every due precaution had been taken, and the anæsthetic administered with the greatest care.—*Brit. Med. Journ.*, Jan. 29, 1876.

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*Chloroform Syncope.*—The *Revue de Thérapeutique Médico-Chirurgicale* for Oct. 1875 records a case of suspended animation in a child aged 6, due to the administration of chloroform. The heart had ceased to act, respiration was suspended, and the *facies* was cadaveric. The child was suspended by the feet, head hanging downwards, and artificial respiration was performed by pressure on the thorax. After a minute of suspension and a dozen efforts at compression of the chest, the colour began to return; a movement of vomiting caused the expulsion of some viscid glairy matter, and presently animation was restored.—*Brit. Med. Journ.*, Jan. 1, 1876.

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*Death from Chloral.*—Another death is reported from the reckless taking of chloral privately. In this case the victim was a lady of about thirty-five, who resided with her step-father at Exeter. She had, it is said, been in the habit for two years past of taking chloral "to soothe pains in the stomach," and had been repeatedly found lying on the floor in an unconscious state from its effects. The preparation she usually took was that known as "Hunter's solution of chloral," which has been ascertained to contain twenty-five grains of chloral to the drachm, and each bottle contained 300 grains. It is calculated that the deceased took 125

grains within two hours. It is futile to caution those who are in the habit of taking sedative narcotic preparations of the risk of doing so except under medical supervision; the only plan likely to succeed is to place heavy restrictions on their sale.—*Med. Times and Gaz.*, Jan. 15, 1876.

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*An Improved Method of Dectecting Sugar in the Urine.*—In the new edition of his work on Diabetes, Dr. J. Seegen recommends a modification of Trommer's test, which consists in filtering the suspected urine two or three times through animal charcoal, and then washing out the latter with a very little distilled water. To this wash-water Trommer's test is applied in the usual way. Very small quantities of sugar can be detected with certainty thus, for the wash-water is generally as sensitive to the test as an aqueous saccharine solution—that is, much more sensitive than the corresponding urine, in which the reaction of the sugar is impaired by the presence of other constituents.—*Med. Times and Gaz.*, Nov. 6, 1875.

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*A Remarkable Birth.*—The *Allgemeine Medicinische Central Zeitung* quotes the following remarkable case from Warsaw. At the railway station of Woloschin, the duties of signaller were performed by a woman, who was in an advanced stage of pregnancy. About five o'clock on the morning of November 24th, a train was approaching, and the woman went on the line to make the signals. She was probably seized with labour-pains as the train approached; for, a few hours later, some labourers found her body literally cut in two, the upper part being completely smashed, while in the sand at the side of the rails lay a child, living and crying, but quite uninjured. At the examination, it was decided that the birth of the child must have taken place after the death of the mother or while she was dying.—*Brit. Med. Journ.*, Jan. 8, 1876.

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*The Force of Imagination.*—Incidentally we may gather from time to time curiously valuable evidence of the worthlessness of subjective evidence respecting mysterious agencies. The *Students' Journal* lately published some ward notes of the impressions which patients occasionally derive from the use of the clinical thermometer. A young woman who was convalescent, and whose temperature had long remained normal, had a slight relapse, which she attributed to having had "no glass under her arm for a week." A man suffering from acute rheumatism, obstinately refused to have his temperature taken any more, saying "it took too much out of him; it was a drawing all his strength away." A man had been in the habit for some time of having his temperature taken daily under his tongue, with a thermometer that had just been doing severe duty in the axillæ of other patients. One night a bran new thermometer was applied to his mouth; next day he declared he was not so well, and said, "the glass was not so strong as usual; he felt at the time the taste was different, and it had not done him so much good." A sister in one of the woman's wards says, that many of the patients think the thermometers are used to detect breaches of the rule against having unauthorized edibles brought in by friends; and she, accordingly, does not disabuse their minds of their innocent superstition. These "impressions" are precisely the sort of evidence on which "metallic tractors," galvanic belts, mesmerists, and animal magnetisers rely for their vogue.—*Brit. Med. Journ.*, Jan. 29, 1876.

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*Medical Statistics of Prussia.*—According to the official reports, in 1874 the number of births was 1,051,806, of which 542,640 were males. Of the whole number of births 975,337 were legitimate, and 76,466 illegitimate. The number of twin births was 12,714, of triple 119, of quadruple 1.

The number of marriages was 244,773. The number of deaths during that year was 692,907, of which 364,547 were males.

The number of suicides was 3075, of which 2527 were males.—*Le Progrès Médicale*, 20th Nov. 1875.

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Obituary Record.—Died, in London, of pneumonia, Jan. 23, aged 46, George Greene Gascoyen, F.R.C.S., Surgeon to the Locke and St. Mary's Hospitals.

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